STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____ LTC Residents Protection	C 02/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADMEADOW HEALTHCARE	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

APR 09 2009
Director's Office

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised report 3/17/09. Resident identifiers revised in F 241. An unannounced annual and complaint visit was conducted at this facility from February 17, 2009 through February 25, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The census on the first day of the survey was one hundred and nine (109). The survey sample totaled twenty three (23) which included twenty (20) active and three (3) closed records. An additional thirteen (13) sub-sampled residents were included for observations and focused reviews.	F 000	F 164 It is the practice of this facility to ensure residents have the right to personal privacy and confidentiality. 1. The C.N.A. for resident # 23 and the C.N.A. for resident # 14 were counseled and educated on the proper techniques for ensuring privacy while providing care to residents.	4/1/09
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	2. The Aide staff will be inserviced on the proper techniques for ensuring privacy while providing care to residents. 3. Random Audits will be conducted weekly for a period of 2 months to ensure compliance with privacy while providing care. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. 5. As noted, the facility did obtain a verbal consent from Resident SS #2's son to photograph the resident.	4/24/09 4/24/09 Ongoing 2/19/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 4/9/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure resident privacy while providing care for three (#23, #14, and SS# 2) out of 23 residents in the sample. Findings include: 1. On 2/24/09 during a skin assessment of Resident #23's arms the Certified Nursing Assistant (CNA), CNA #3 pulled back the resident's bedding exposing the resident from the knees up. The resident was wearing a hipster undergarment and undershirt. The privacy curtain was not pulled closed and the door to the room remained open. The resident's roommate was in the room and the roommate had a visitor who entered the room during the observation. 2. On 2/24/09, during an observation of a catheter/peri care, CNA#1 failed to cover or drape Resident #14's genital area when she left the resident to obtain a clean brief for him. Although the privacy curtain was pulled, Resident #14 was left exposed to two surveyors who were at his bedside within the curtained area. During an interview on 2/24/09 at 2:45 PM, CNA #1 confirmed that she should have covered Resident #14 with a towel to prevent unnecessary exposure of his private parts. Findings were discussed with the ADON (Assistant Director of	F 164	6. An audit of all signed Photograph Authorizations was performed to check for accuracy with proper responsible party authorization. 7. Audits of subsequent Photograph Authorizations will be performed by the Activities Director to ensure compliance with proper responsible party authorization. 8. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	4/1/09 4/24/09 Ongoing

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F 164	Continued From page 2 Nursing) on 2/24/09, who confirmed the facility failed to provide Resident #14 with privacy during care. 3. On 2/18/09 at 2:15 PM, a visitor was observed with a camera talking with numerous residents in the Warner Unit. An interview with the facility's Activities Director (AD) on 2/18/09 at 2:45 PM revealed that the visitor was a student volunteer and that this visitor was authorized by one resident, Resident SS #2 to take this resident's picture. Review of the "Photograph Authorization" dated 2/3/09, which authorized the student volunteer to take, use and disclose photographic images of Resident SS #2 revealed that the resident herself signed the document. Review of the most recent MDS assessment dated 12/17/08 indicated that Resident SS# 2 was coded as moderate impaired for daily decision making, poor decision, and required cue/supervision. Additionally, clinical records revealed that the resident's son was the responsible party for Resident SS#2. Follow-up interview with the AD on 2/18/09 at 3:30 PM confirmed that the resident's son did not authorize photographs of this resident to be taken. Subsequently, on 2/19/09 at 9 AM, the AD contacted the resident's son/ responsible party and the facility obtained verbal photograph authorization.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have	F 225	F 225 It is the practice of this facility to report all alleged violations involving mistreatment, neglect, or abuse in accordance with State law through established procedures. 1. The staff member, DA #1, is no longer employed at the facility.	

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F 225	Continued From page 3 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to report an	F 225	2. All staff will be inserviced on the proper procedures for reporting of alleged violations involving mistreatment, neglect, or abuse in accordance with State law. 3. Incidents will be reviewed at the facility's morning stand up meeting to ensure compliance with proper reporting procedures. 4. The QI/QA committee will review all incident reports to ensure compliance with proper reporting procedures.	4/24/09 Ongoing Ongoing

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F 225	Continued From page 4 allegation of mistreatment for one (#12) out of 23 sampled residents. Findings include: Review of Resident #12's nurse's note dated 10/2/08 and timed 4 P.M. documented that the resident informed, Nurse #6 that the small food cart hit the resident's knees. Body check was completed with no redness or bruising at this time. Subsequent nurse's note dated 10/3/08 timed 11:45 AM documented Resident #12 with complaints of knee pain and new order for x-ray of bilateral knees ordered on 10/3/08. Bilateral knee x-ray dated 10/3/08 revealed both knees with modest osteoarthritis, however, no fracture, dislocation, or joint effusion. Review of the facility's incident/accident report and investigations dated 10/2/08 revealed two witness interviews; Residents SS# 11 and SS#12. Both of the residents reported observing Resident #12 being hit by the food cart which was being transported by the dietary aide (DA #1) during lunch hours. Interview with the Food Services Director (FSD) on 2/24/09 at 3 PM confirmed that the DA #1 did not report the above incident to him and that the FSD became aware of the incident through the Nursing Department. The FSD indicated that verbal counseling was completed with DA #1 reiterating being careful with transporting the cart. Interview with the Administrator on 2/24/09 at 1:15 PM revealed and confirmed that the facility did not report the above incident since it was their assessment that the above incident was an accident, thus, did not require reporting to the State Agency.	F 225		

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F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, employee record reviews, and staff interview, it was determined that the facility failed to ensure that two (2) of two (2) physical therapy staff persons received abuse training upon hire or on their anniversary (Employees #1 and #2). Findings include: Two physical therapy staff had no abuse training upon hire or upon their anniversary. Review of employee files indicated that Employee #1 was hired on 5/28/08. There was no evidence that Employee #1 had received abuse training upon hire. Review of employee files indicated that Employee #2 was hired on 5/14/07. There was no evidence that Employee #1 had received abuse training upon hire and on her annual anniversary date from 5/14/07 through 5/14/08. Interview with the two staff revealed they did not get abuse training. Review of the facility Administrative Manual Policy and Procedure entitled "Abuse and Neglect/Staff Training" under "Section 2" indicated that, "All employees, upon hire, and annually thereafter will receive mandatory training on issues related to	F 226	F 226 It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. 1. Employee #1 and Employee #2, both contract physical therapy staff, were provided the appropriate abuse training. 2. An audit of the employee files for all contract physical therapy staff was completed to ensure compliance with the appropriate abuse training. 3. The contract physical therapy company used by this facility has developed appropriate abuse training, and the facility will also provide the appropriate abuse training upon hire and upon their anniversary. 4. The facility Human Resources Director will conduct an audit at the time of hire and annually thereafter of contract Physical Therapy Staff files to ensure appropriate documentation of abuse training.	2/26/09 2/27/09 3/9/09 Ongoing

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F 226	Continued From page 6 abuse prohibition practices including: Resident rights/abuse, neglect, mandatory reporting requirements, grievance policy." Interview with the Staff Development Nurse during the survey revealed that abuse training is required to be provided yearly and upon hire for all employees. Interview with Employees #1 and #2 revealed they never had abuse training upon hire and yearly. Facility staff interview revealed that the facility did not offer training on abuse prohibition to the therapy company employees.	F 226 F 241	It is the practice of this facility to treat residents in a manner which respects, maintains and enhances their dignity. Further investigation revealed that Resident 1. 12 had been ill and had not come to the dining room for several meals. The Food Service Department had sent a tray to the unit where Resident 12 resides. The Aide had brought the tray to Resident 12 in the Dining Room prior to the beginning of service. Once the error was discovered, Food Service Staff immediately served Residents #13, SS#11 and SS#3 and the FSD explained the situation to them and reassured them that this is not the practice of the facility. 2. It is the policy of this facility to serve all residents seated at a table at the same time. All residents are evaluated as to the ability to eat their meals in the Dining Rooms. 3. The Food Service Staff will be inserviced on the need to serve all residents seated at a table at the same time. 4/15/09 Random Audits will be conducted twice a week for 4 weeks by the FSD to ensure compliance. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. Ongoing 1. Resident SS#3 was attended to and groomed appropriately following the observation.	
F 241 SS=B	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and dietary staff interview, it was determined that the facility failed to treat and care for four residents (#13, SS#11, SS#13, and SS#3) out of 23 sampled in a manner that respected, maintained or enhanced their dignity. Findings include: 1. Observations of the main dining room on 2/18/09 during lunch revealed that one resident, Resident 12 was eating and finished his meal while three other residents (#13, SS#11, and SS#13) were seating at the same table had no meals for at least 15 minutes. Residents at the table appeared frustrated and angry. One dietary staff in the dining room was observed taking orders from other residents in the dining			

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F 241	Continued From page 7 room during this observation but never approached the three residents until it was brought to her attention. 2. Resident SS#3, a female resident who relied on staff for grooming and hygiene was observed with long, unwanted facial hair on the chin on 2/19/09 at 1:15 PM.	F 241	2. An audit of other residents who rely on staff for grooming and hygiene was performed to ensure appropriate care was provided. 3. The C.N.A.'s will be inserviced on the need to provide appropriate grooming and hygiene to those who rely on staff. Random audits will be conducted weekly for a period of 2 months by the Unit Managers to ensure compliance.	4/15/09
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure the right of one resident (#8) out of 23 sampled residents to choose to refuse a shower on her scheduled shower day. Findings include: On 2/20/09 at 2 PM, Resident #8 was observed seated in the hallway outside of her room. She complained to a surveyor that she had been given a shower that morning against her wishes. She stated that the day before, she had been given a shower, had her nails cut and hair done at the beauty shop. Resident #8 was visibly upset and stated that she had hit a CNA with both fists (demonstrating to the surveyor) and pulled the	F 242	4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. F 242 It is the practice of this facility to ensure the resident has the right to choose activities, schedules and health care consistent with his/her interests, assessments and plans of care. 1. The C.N.A. who cared for Resident #8 was educated on the resident right to refuse and/or change the shower day and time. 2. The Nursing Staff will be inserviced on the resident's right to refuse and/or change the day and time of the resident's shower.	Ongoing 2/20/(4/15/(

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F 242	Continued From page 8 CNA's hair while stating that she did not want a shower because she had her hair done the day before. During an interview on 2/20/09 at 2:30 PM, Nurse #3 confirmed that Resident #8 had received a shower on 2/20/09 and that CNA #2 had reported that Resident #8 had pulled her hair. Nurse #3 then went to interview Resident #8. Resident #8 reported to Nurse #3 that she had been showered that morning against her wishes. During an interview on 2/23/09 at 10:30 AM, CNA #2 stated that the resident was mistaken about being showered on 2/19/09(Thursday). CNA #2 believed Resident #8 was confused because her hair was done on Thursday and usually, it is done on Fridays after her scheduled shower. Upon further questioning, CNA #2 agreed that the resident's statements about having a shower the day before and her behavior of pulling the CNA's hair had indicated that the resident did not want her shower but received one anyway. CNA #2 confirmed that Resident #8 had her hair washed during the shower and subsequently, had another hair appointment on Friday. The facility's document entitled, "Resident's Rights Abuse & Neglect" was reviewed. It listed resident rights which included, "The right to make choices regarding activities, schedules, health care and other aspects of his or her life." During an interview on 2/24/09, the ADON confirmed that Resident #8 should not have been given a shower that she had refused.	F 242	3. Random audits will be performed by the Unit Mangers to ensure compliance with the resident's right to refuse and/or change the day and time of showers. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	4/24/09 Ongoing
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive	F 246	It is the practice of this facility to provide the residents with reasonable accommodations of individual needs and preferences. 1. Resident #4 and Resident SS #4 were assessed as to the ability to properly use the call light. Both demonstrated the ability to use the call light appropriately. The call lights immediately placed within reach of both residents. 2. Residents are assessed upon admission, quarterly and upon significant change as to the ability to properly use the call light. 3. The Nursing Staff will be inserviced to ensure that those residents who demonstrate the ability to use the call light have the call light within reach. Random Audits will be conducted weekly for a period of 2 months by Nursing Administration to ensure compliance.	3/20/09 4/15/09

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F 246	Continued From page 9 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that two (#4 and SS#4) out 23 sampled residents and additional residents for observation received reasonable accommodation for their needs. Two residents were found to have their call bell out of reach. Findings include: 1. Resident #4 was observed on 2/18/09 to be in bed with the call bell out of reach. The resident said her bed was wet and she needed help pointing to a damp spot on the side of the bed. The surveyor gave the resident the call bell and she was able to call for assistance. On 2/19/09 at 1:35 PM the resident was again found in bed with the call bell out of reach. The resident was again handed the call bell and the resident demonstrated which button to push to get assistance. On 2/25/09 at 8:35 AM the call bell was again found to be out of reach. 2. Resident SS#4 was observed during the initial tour on 2/17/09 to be in bed with the call bell out of reach on the night stand with the cord caught behind the night stand and inaccessible to the resident. The resident was provided the call bell	F 246	4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing

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F 246	Continued From page 10 by the surveyor and the resident demonstrated how to use it correctly.	F 246	F 253	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour with the maintenance and environmental service directors on 2/17/09, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior. Additionally, feces was observed on the toilet seat in Resident #18's bathroom on 2/20/09 and 2/23/09. Findings include: 1. Debris inside the air conditioner (ac) unit grills in resident rooms 106, 113, 204, 205, 209, 219, 223, 229, 306, 311, 316 windows was observed. Additionally, heavy dust was observed in the filter of the air conditioners of room 205, 209, 214, 223, 229, 106, 113, 311, and 316. 2. Dust/dirt was observed on wheelchairs belonging to residents in room 214A, 229A, 231A, 306A, 309B, 311A. Additionally, two (2) of ten (10) wheelchairs in the physical therapy room and two (2) of six (6) wheelchairs in the AJ Cox lounge were observed dusty/dirty. Additionally, observations on 2/23/09 at 7:12 AM revealed one shower chair soiled with fecal material in the 200 unit common shower room	F 253	It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. The debris inside the air conditioner unit grills in resident rooms and the heavy dust observed in the filters of air conditioners in resident rooms were removed and cleaned. 2. The dust/dirt observed on wheelchairs in resident rooms, in the physical therapy rooms and in the AJ Cox lounge were removed and cleaned. The shower chair in 200 shower room was cleaned and sanitized. 3. The dining room tables in the main dining area were cleaned and sanitized on 2/23/09. Resident #18's bathroom was cleaned and sanitized at 2:00pm on 2/20/09. 4. Nurse #5 will be counseled and educated on the proper reporting of unsanitary conditions. 5. The air conditioner unit grills and filters will be added to the daily rounds checklist for the Maintenance Director. 6. The facility maintains a wheelchair cleaning schedule.	2/27/09 2/27/09 4/1/09 4/1/09

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F 253	Continued From page 11 (Spa). 3. Observations of the dining room tables in the main dining area on 2/17/09 and 2/18/09 prior to lunch revealed food debris/deposits on the tables. The tables were set up with utensils and cups for the resident's lunch that day. Dietary staff interview revealed the tables should have been cleaned prior to setting the tables and they had not been wiped clean after dinner last evening. 4a. Cross refer F441 example #2 On 2/20/09 at 12:55 PM, Resident #18 was started with her nebulizer treatment. At 1:15 PM, feces was observed on the raised toilet seat in Resident #18's bathroom. This was in full view of Nurse #5, who was rinsing out the resident's nebulizer post treatment at the bathroom sink Nurse #5 neither cleaned the toilet seat nor called housekeeping but instead left the Resident's room to go to lunch at 1:33 PM. The facility failed to maintain a clean and sanitary bathroom for at least 35 minutes. Findings were confirmed during an interview with Nurse #5 on 2/25/09. 4b. On 2/23/09 at 8:05 AM, feces was again observed on the raised toilet seat in Resident #18's bathroom. Resident #18 stated that her bathroom was "finally sanitized yesterday" (2/24/09). Resident #18 continued with symptoms of diarrhea and complained that the bathroom is often "dirty" and is shared with her roommate. Findings were discussed with the administrative	F 253	7. The dining room tables will be added to the daily rounds checklist for the Food Service Department.	4/1/09
			8. All staff will be inserviced on the proper reporting of unsanitary conditions.	4/24/09
			9. Random Audits will be performed by the Environmental Services Director 3 times a week for a period of 4 weeks to ensure compliance in cleaning and sanitizing with the following: • Air Conditioner Grills and Filters. • Facility Wheelchairs • Dining Room Tables • Shower Room Chairs • Resident Bathrooms	4/24/09
			The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing

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F 253	Continued From page 12 staff during the informational meeting on 2/25/09.	F 253		
F 254 SS=B	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews it was determined that the facility failed to ensure bath linens were provided in good condition for residents to use as evidenced by frayed and rough towels and wash clothes. Findings include: 1. During the environmental tour on 2/17/09 of the laundry room, the surveyor observed a stack of folded towels and wash clothes in the laundry clean linen room storage area that were frayed. Interview with the environmental director revealed they separate the frayed towels after they are folded. Two (2) of nine (9) frayed wash clothes were observed in the Broad street gym on 2/18/09 at 8:35 AM, and one (1) of five (5) frayed towels in the 300 unit hallway clean linen cart. Interview with the laundry personnel on 2/23/09 revealed the frayed towels and wash clothes were placed in circulation after our observations on 2/17/09 by mistake. 2. During a group interview with residents on 2/18/09, the residents stated that the towels were rough and they were concerned about using them. Throughout the survey, the surveyor observed that all wash clothes and towels were rough to the touch stored in the 200 and 300 unit clean hallway carts, the 300 unit living room towels, clean linen storage areas and laundry.	F 254 F 254	It is the practice of this facility to provide clean bed and bath linens that are in good condition. 1. The facility audited all towels and wash clothes and discarded those that were frayed. 2. The facility has a policy for the separation and discarding of frayed towels. The Housekeeping Staff will be inserviced on the policy to ensure compliance with the separation and disposal of frayed towels. 3. The Environmental Services Director will perform Random Audits 3 times a week for a period of 4 weeks of the towels and wash clothes in use to ensure compliance. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. 1. As noted, the facility contacted the chemical supplier and adjusted the concentration of fabric softener use during the cleaning process.	2/26/09 4/15/09 4/24/09 Ongoing

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F 254	Continued From page 13 On 2/24/09, observations of the towels and wash clothes in the clean area of the laundry revealed rough towels after Ecolab made a change in the softener. Interview with nursing staff revealed the towels were rough. The staff stated they were concerned the rough towels would cause bruising and breakage of resident skin, especially those residents with fragile skin.	F 254	2. The facility re-contacted the chemical supplier and again adjusted the concentration of fabric softener. After this second adjustment, the facility solicited the opinion of the residents and staff regarding the softness of the towels.	3/4/09
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (#19) out of 23 sampled residents had a care	F 279	3. The Environmental Services Director will perform Random Audits 3 times a week for a period of 4 weeks to ensure softness of the towels is appropriate. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. F 279 It is the practice of this facility to develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the resident's needs. 1. A physicians order was obtained for Resident #19 for the left ankle foot orthosis (AFO). A care plan was also developed for the use of the left ankle foot orthosis (AFO). 2. An audit of all orders and care plans was conducted to ensure compliance with actual care needs of the resident's.	4/24/09 Ongoing 2/23/09 3/20/09

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F 279	Continued From page 14 plan which reflected their actual care need for a leg brace. Findings include: Cross refer F514. On 2/23/09 at 1:45 PM, Resident #19 was observed out of bed, in the wheelchair with a brace on his left lower extremity. Interview with the resident revealed that the facility staff assisted in placing and removing the brace. Record review lacked evidence of a physician's order for the brace, a left ankle foot orthosis (AFO) and an interview with Nurse # 7 on 2/23/09 at 2:30 PM confirmed that the facility failed to obtain the order for this orthosis. Additionally, record review lacked evidence of a care plan for the use of the left AFO.	F 279	3. Random Audits will be conducted weekly for a period of 2 months by the RNAC to ensure compliance with orders and care plans matching the actual care needs of the residents. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	4/15/09 Ongoing
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to ensure that four residents (#23, SS#1,#13, #17) in the sample of 23 received the care and services necessary for their highest level of well-being. Resident #23 did not have arm protectors on, Resident SS#1 did not receive medication as ordered and two residents (#13,	F 309	F 309 It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 15 #17) did not have adequate monitoring and treatment for constipation. Findings include: 1. Resident #23 had a physician's order dated 12/30/08 for the use of bilateral protective sleeves to arms to be removed only for hygiene. The resident had very fragile skin. An interview with CNA#1 that cared for Resident #23 on 2/20 and 2/21/09 7 AM to 3 PM shift revealed that the resident did not have arm sleeves on when she started her shift. It was also revealed that there were no sleeves available in the resident's room after AM care. The aide found a set of sleeves later in the shift and placed them on the resident. Cross refer F425 Example #1 2. Resident SS#1 was admitted to the facility on 2/18/09 at about 5:55 PM with diagnoses which include hypertension, chronic alcohol use, likely alcohol withdrawal, history of seizures and carotid aneurysm. The resident's ordered medications included; Aspirin 81 mg daily (qd), Librium 10 mg twice daily (bid), Nexium 40 mg qd, Nitrofurantion 50 mg bid x 4 days, Thiamine 100 mg qd, Folate 1 mg qd, Multivitamin qd, and Mag-Ox 400 mg bid x 5 days. Resident SS#1's medications did not arrived until 1 PM on 2/19/09. The medications were mislabeled with the name of a resident on another unit with a similar name and could not be administered until the labels were corrected. The resident received the twice a day medication at 8 PM on 2/19/09 and the daily medication at 8 AM	F 309	1. The bilateral protective sleeves were applied to Resident # 23. The facility ordered additional protective sleeves to ensure a supply was readily available. 2. An audit of residents with orders for protective sleeves was conducted to ensure compliance. 3. The Unit Manager will conduct random audits weekly for a period of 2 months of residents with orders for protective sleeves to ensure correct placement. 4. The results of these audits will be reported to the QI/QA committee. The committee will determine the need for further audits. 5. The medications for Resident SS#1 were delivered and administered at 8:00pm on 2/19/09. The Pharmacy was also called and informed of the mistake in labeling. 6. The Nursing Staff will be inserviced on the proper procedure for notifying the pharmacy and physician when a delay in medication delivery occurs. 7. Nursing Administration will audit New Admission Med Orders to ensure compliance with timely medication administration.	2/21/09 4/24/09 Ongoing 4/24/09 4/24/09

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F 309	Continued From page 16 on 2/20/09 over 24 to 36 hours after admission to the facility. The physician was not consulted about the delay in the medications. An interview with the DON on 2/25/09 at 9:14 AM revealed that the facility practice should have been to contact the pharmacist and the physician to determine what medications needed to be ordered stat (right away). The stat medications could have been ordered through the contract pharmacy and delivered within 4 hours. 3. Resident #13 had a diagnosis of constipation and had orders for a bowel protocol that included Milk of Magnesia (MOM) as needed for constipation. If unrelieved in 8 hours a Dulcolax suppository was to be administered and if unrelieved by the suppository in 8 hours a Fleets enema should be administered. On 12/12/08 at 8 PM a Fleets enema was administered for constipation. MOM and Dulcolax were not utilized. The resident was documented as having bowel movements (BMs) on 12/9, 12/11 and 12/12/08 prior to the Fleets. On 12/15/08 at 7:30 PM MOM was administered followed by Dulcolax at 3:30 AM on 12/16/09. The resident was documented as having BMs at least twice on 12/13 and 12/12/08. Resident #13 had no BMs on 12/22, 12/23, 12/24, and 12/25/08. There was no evidence of an assessment for constipation or initiation of the bowel protocol. On 12/26/08 the resident had two medium sized BMs. Staff administered MOM on 12/27/08 at 1 PM. On 1/16/09 MOM was administered for	F 309	8. These audits will be reported to the QI/QA committee. The committee will determine the need for further audits. 9. Resident #13 and Resident #17 were assessed for current status regarding constipation. Neither resident exhibited any signs or symptoms of constipation. 10. The Nursing Staff will be inserviced on the established facility BM protocol and the need for appropriate assessment. 11. Nursing Administration will conduct Random Audits weekly for a period of 2 months to ensure compliance with proper administration of the BM protocol. 12. The results of these audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing 3/20/09 4/24/09 4/24/09 Ongoing

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F 309	Continued From page 17 constipation with 3 days of no BMs. At 8 PM Dulcolax was administered followed by a second Dulcolax on 1/17/09 at 1220 AM. There was no physician order for the use of the second Dulcolax. The resident had documented BMs on 1/17/09 and 1/18/09. MOM was administered on 1/20/09 with no assessment for constipation. 4. Resident #17 was documented has having three BMs on 11/23/08, one BM on 11/24/08 and one BM on 11/25/08. MOM was administered on 11/26/08 without indication of an assessment for constipation.	F 309		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure that one (#10) out of 23 sampled residents received the staff assistance to maintain a restorative ambulation program. Findings include: Resident #10 was admitted to the facility on 1/17/07. The MDS assessments dated 11/26/08, 9/7/08 and 6/15/08 indicated that the resident did not ambulate during the review but was independent with locomotion in the facility. A therapy note dated 4/28/08 stated that therapy services were being discontinued due to lack of	F 311	It is the practice of this facility to provide the residents with appropriate treatment and services to maintain or improve their abilities. 1. Resident #10 was evaluated by Therapy and is on active caseload for Physical Therapy. 2. An audit of residents currently care planned for Restorative Ambulation was completed to ensure compliance with the restorative program. 3. The RNAC will perform Random Audits weekly for a period of 2 months of residents care planned for restorative ambulation to ensure compliance with plan of care and ADL flow records. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	2/25/09 4/24/09 Ongoing

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F 311	Continued From page 18 participation and the plan was for the resident to ambulate to the dining room with a rollator (wheeled walker) and supervision for all meals. It was noted that the resident would not ambulate to the dining room unless it was part of a "therapy session". There were no further therapy notes about the restorative program. A care plan was developed that indicated the resident would ambulate to the dining room with one person assist for lunch and dinner 7 days a week and document on Activities of Daily Living (ADL) flow record. Staff was to notify therapy if there was a change in ambulation status. Care plan entries on 12/23/08 and 2/17/09 indicated the resident ambulated in her room and to and from the bathroom but did not mention the ambulation to the dining room. Review of the ADL flow sheets revealed no entry for the restorative ambulation to the dining room. An interview with the resident on 2/20/09 at 1:10 PM revealed that staff were not assisting her to ambulate to the dining room. An interview on 2/20/09 at 1:40 PM with the unit manager revealed that she was unaware the resident was on a walk to dine program and that a new therapy screen would be requested.	F 311		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		

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F 312	Continued From page 19 by: Based on record review, interview, and observation it was determined that the facility failed to provide nail care to one (#14) out of 23 sampled residents. Findings include: On 2/24/09, Resident #14 was observed sitting in a wheelchair opposite the nurse's station with long, jagged and thick fingernails. Resident #14's care plan, dated 4/16/08, addressed the problem "chronic fungal infection of fingernails" and included the approaches: "dermatology consults... nail care as ordered..." The facility's policy titled, "Nail Care... to maintain nails for optimal comfort, appearance and integrity..." was reviewed. Review of Resident #14's clinical record revealed that the resident had a dermatology consult on 4/8/08 for fungus to nails and his left hand. Loprox cream was recommended and subsequently ordered. Review of the nurses notes, dated 4/10/08 and timed 8:30 AM, revealed that a request had been made for a podiatrist to come and cut the resident's fingernails but that "... legally podiatrist stated that he could not cut fingernails." During an interview on 2/24/09, the Assistant Director of Nursing (ADON) stated that she thought the family cut his nails but was unsure when that last happened. Review of Resident #14's clinical record lacked evidence of any further assessments, consults or documentation of the resident's fingernails being cut or trimmed. During an interview on 2/25/09, the ADON	F 312	F 312 It is the practice of this facility to provide residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Resident #14 was provided nail care by Nursing. He's nails were soaked, cut and filed to an appropriate length. — 3/6/09 2. All residents were checked to ensure that the appropriate nail care was being provided. — 3/9/09 3. Random Audits will be performed weekly for a period of 2 months by the Unit Managers to ensure compliance with appropriate nail care. — 4/15/09 4. The results of these random audits will be reported to the QI/QA committee to determine the need for further audits. — Ongoing	

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F 312	Continued From page 20 confirmed that the clinical record lacked evidence of continued monitoring or care of Resident #14's fingernails. She then telephoned the family to clarify the issue of the resident's fingernails and stated that she will follow-up with family on Monday, 3/2/09.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview it was determined that the facility failed to ensure that one (#4) out of 23 residents received the care necessary to prevent new pressure sores from developing. Findings include: Resident #4 was admitted to the facility on 12/15/05. The resident's most recent MDS assessment dated 12/28/08 indicted the presence of a stage one pressure sore. The resident had a history of resolved pressure ulcers. The MDS also indicated that the resident required extensive assistance with bed mobility and was dependent on staff for all other activities of daily living. The resident was assessed on 1/16/09 as being at high risk for pressure ulcers.	F 314	F 314 It is the practice of this facility to ensure that a resident does not develop pressure sores, unless clinically unavoidable, and provides necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. The approach to off load heels while in bed was added to Resident #4's care plan. The order to off load heels while in bed was carried out. 3/3/09 2. All residents with physician orders to off load heels while in bed where audited to ensure that appropriate care plans were in place. 3/20/09 3. Random Audits will be performed weekly for a period of 2 months by Nursing Administration to ensure compliance with care plans and orders for the off loading of heels while in bed. 4/15/09	

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F 314	Continued From page 21 A physician's order dated 1/23/09 indicated the need to off load heels in bed. This approach was not added to the resident's care plan. Observations on the following dates and times revealed the resident was in bed without off loading of the heels; 2/18/09 12:11 PM, 2/19/09 11:35 AM and 1:35 PM, 2/20/09 2 PM, 2:30 PM and 3:28 PM, 2/23/09 8:30 AM and 2:34 PM, 2/24/09 10:50 AM and 2/25/09 8:35 AM.	F 314	4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined that the facility failed to ensure that appropriate treatment and services to prevent urinary tract infections (UTIs) and to restore as much normal bladder function as possible for two out of (#14 and #12) out of 23 sampled residents. Resident #14 had an indwelling catheter and a history of UTIs. Facility failed to assess Resident #12's urinary incontinence after the Foley catheter was removed to restore as much normal bladder function as possible. Findings include:	F 315	F 315 It is the policy of this facility to ensure that a resident is not catheterized unless the clinical condition demonstrates that it is necessary, and to ensure that a resident who is incontinent of bladder receives appropriate treatment to prevent infection and to restore as much normal function as possible. 1. The C.N.A. #1 was counseled and educated on the proper techniques for foley catheter care. 4/1/09 2. All C.N.A. staff will be inserviced on the proper techniques for foley catheter care. 4/24/09 3. Random Audits will be performed weekly for a period of 2 months by the Unit Managers to ensure compliance with proper foley catheter care. 4/24/09	

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F 315	Continued From page 22 1. Resident #14 was admitted to the facility on 8/27/07 with diagnoses that included retention of urine, and BPH (Benign Prostatic Hyperplasia, also known as an enlarged prostate). Resident #14's readmission and quarterly MDS assessments dated 11/16/08 & 12/25/08 respectively revealed that he had an indwelling catheter, was incontinent of bowel, and needed extensive assistance of staff for hygiene and toileting needs and a history of UTIs. Resident #14's care plan, dated 8/28/07, addressed the problem "potential for urinary tract infection r/t (related to) indwelling catheter" and included approaches: "consistent, proper perineal care..." The facility's policy titled, "Catheter Care... to prevent infection of the urinary tract" was reviewed. On 2/24/09 at 1 PM, CNA #1 was observed providing catheter/perineal care to Resident #14. The resident had an indwelling catheter and had been incontinent of stool. CNA #1 correctly used disposable wipes first cleaning the right and left groin areas using single strokes from front to back or turning wipe to a clean surface except for two times when she failed to turn the wipe in the groin areas while trying to remove traces of a cream in these areas. She also failed to wash her hands and change gloves before applying new cream to the groin areas. CNA #1 removed her gloves, positioned resident on his right side, put on new gloves and proceeded to wipe the stool off in a front to back motion. When finished, CNA #1 applied barrier cream to the resident's buttocks while still wearing soiled gloves. The CNA failed to wash her hands and change gloves before applying the barrier cream to ensure that no fecal material was present. CNA #1 confirmed	F 315	4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing
			5. A two day voiding diary was completed for Resident #12 and a toileting plan was implemented. The plan is to toilet the resident every two hours and as requested.	3/27/09
			6. An audit was completed on residents who are incontinent of bladder to ensure that a two day voiding dairy had been instituted.	4/1/09
			7. Nursing Administration will perform random audits weekly for a period of two months to ensure that the two day voiding diary has been completed for residents who are incontinent of bladder.	4/24/09
			8. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing

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F 315	Continued From page 23 findings. Findings were reviewed and confirmed with the ADON of Nursing on 2/24/09. 2. Resident #12's readmission MDS assessment dated 1/30/09 indicated the resident had an indwelling catheter in the bladder and was frequently incontinent of bladder during this assessment period. In addition, required total assistance with toileting. Record review revealed that the Foley catheter was discontinued on 1/30/09 per physician's order. Review of CNA flowsheet for February 2009 revealed that the resident was totally incontinent of urine. A review of the facility's policy titled "Incontinence (Treatment)" indicated that a resident who is incontinent of bladder will be assessed utilizing a two day voiding diary to determine a voiding pattern. Record review lacked evidence of an incontinence assessment to restore or improve normal bladder function to the extent possible. An interview with Nurse #6 on 2/19/09 at 11:30 AM revealed that it was her understanding that the facility does not utilize a two day voiding diary to assess urinary incontinence. An interview with the DON on 2/19/09 at 3:30 PM confirmed that the facility failed to follow their policy to assess urinary incontinence by failing to complete a voiding diary for Resident #12.	F 315		
F 323	483.25(h) ACCIDENTS AND SUPERVISION	F 323		

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F 323 SS=E	Continued From page 24 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to maintain an environment free from accidents. Findings include: 1. On 2/19/09 at 10 AM, staff nurse was observed carrying an unsecured oxygen tank to a resident in Warner Unit. 2. On 2/20/09 at 1:20 PM, staff from the Rehabilitation Department was observed in the Warner Unit hallway carrying an unsecured oxygen tank to a resident's room. 3. A medicine cart on the 200 unit of the facility by the nursing station on 2/18/09 was observed unlocked and unattended and accessible to residents. Staff interview confirmed this finding. 4. On 2/17/09, chemicals accessible to residents in unlocked areas were observed as follows: a. An unlocked shelf in a cabinet above the sink in the A.J. Cox lounge had bottles of shampoo, body lotions, cutex, and activity paint. b. An unlocked closet in the physical therapy room on 2/17/09 at 11:00 AM, and 2/18/09 at 8:35	F 323	F 323 It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance and assistive devices to prevent accidents. 1. The facility initiated a full facility inspection and either removed and/or secured all chemicals. The scissors observed in the Marquis Theater and Therapy Room were secured. 2. All staff will be inserviced on proper techniques for chemical storage and safety awareness regarding the storing of scissors. 3. Nursing and Therapy Staff will be inserviced on the proper procedure for the transporting of oxygen tanks. 4. Nursing Staff will be inserviced on the proper procedures for the locking of medicine carts. 5. Nursing Staff will be inserviced on slip and fall prevention tips and the notification of fall or safety issues.	2/17/09 2/23/09 4/24/09 4/24/09 4/24/09

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F 323	Continued From page 25 AM stored the following: (2) 32 ounces of Biofreezepain reliever gel (no safety info on bottle) (1) Ultra sound transmission gel (caution for external use) - 1 gal and smaller bottle (1) Omni gel bottle (1) Biofreeze bottle top of cabinet In the bathroom of the therapy room, on top of the toilet, one perineal wash bottle and two bottles of odor spray cans were observed. c. On 2/23/09 outside room 224 in the hallways, the clean linen cart was observed storing two bottles of perineal wash, one bottle of lotion, and three protective body creams. On 2/17/09, a perineal bottle was stored on top of the clean linen cart outside room 223. On 2/23/09, two perineal bottles, one bottle of lotion, and three bottles of protective skin creams were observed outside room 224 inside the clean linen cart. A perineal wash bottle, one bottle of Evoke lotion, and one bottle of protective skin cream was observed inside the clean linen cart outside room 229. Interview revealed these chemicals should not be stored in the clean linen carts. d. On 2/17/09 in the Marquis Theater / activity room, under the sink inside the cabinet, an unlocked bottle of germicidal cleaner, one spray can of pot/sink cleaner, and one dishwasher cleaner were stored unlocked. Acrylic paint bottles in the 300 lounge were stored in an unlocked drawer on 2/17/09. e. On 2/23/09 at 1:35 PM, the 100 unit clean utility room storing facility supplies was observed	F 323	6. The Food Service Department will be inserviced on the proper food temperatures for food served to residents. 7. Administration will conduct random audits weekly for a period of 2 months to ensure compliance with proper chemical storage and safety awareness. 8. Nursing Administration will conduct random audits weekly for a period of 2 months to ensure compliance with the locking of medication carts and proper oxygen tank transportation. 9. The Registered Dietician will conduct random food temperature audits weekly for a period of 2 months to ensure compliance with proper food temperatures. 10. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	4/24/09 4/24/09 4/24/09 4/24/09 Ongoing

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F 323	Continued From page 26 unlocked and accessible to residents. The unit was locked after the surveyor left the room. 5. A pointed pair of scissors inside a drawer in the Marquis Theater activity room was observed accessible to residents and unlocked on 2/17/09. A pair of scissors in the physical therapy room dining area on 2/17/09 at 11:00 AM was accessible on top of a cart with no staff in view. 6. On 2/17/09, a puddle of water was observed in the 300 common resident shower "Spa" or room. 7. On 2/18/09, a bowl of soup at 200 degrees Fahrenheit was served to a resident in the 200 unit.	F 323		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview it was determined that the facility failed to administer medications in accordance with the plan of care for two residents (SS#9 and SS#10). The medication error rate was 5.8%. Findings include: 1. During a medication pass observation of Nurse #1 on 2/17/09 at 4:10 PM, the nurse incorrectly crushed Prevacid Solutab 30 mg. (milligram), mixed with applesauce, and administered the medication to Resident SS#10. Record review of the interim physician's order dated 2/17/09 confirmed the above order, however, there was no order to crush the	F 332	F 332 It is the practice of this facility to ensure that it is free of medication error rates of five percent or greater. 1. Both Nurse #1 and Nurse #2 were counseled and educated on the proper techniques for the passing of medications, specifically the crushing of medications and following of medication orders. 4/1/09 2. The Nursing Staff will be inserviced on the proper techniques for the passing of medications. 4/24/09	

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F 332	Continued From page 27 medications. An additional medication pass observation on 2/18/09 at 4:04 PM, Nurse #2 incorrectly crushed Prevacid Solutab 30 mg. (milligram), mixed with applesauce, and administered the medication to Resident SS#10. According to Institute for Safe Medication Practice's list for "Oral dosage forms that should not be crushed" list dated February 9, 2008, the above medication should not have been crushed. Interview with the contracted pharmacy staff on 2/18/09 at 1 PM confirmed that the Prevacid Solutab should not be crushed. Above information reviewed with the DON on 2/25/09 at 11 AM. 2. During a medication pass observation of Nurse #1 on 2/17/09 at 3:57 PM, the nurse administered one drop of Systane 0.4 % eye lubricant to Resident SS#9's left and right eye. Record review of February 2009 monthly physician's order sheet revealed an order for Systane 0.4 % eye lubricant, one drop to right eye four times a day. An interview with the resident's unit manager, Nurse #3 on 2/17/09 at 2 PM confirmed that the order was only for the right eye.	F 332	3. Nursing Administration will perform random audits weekly for a period of 2 months of the medication pass to ensure compliance of the proper techniques.	4/24/09
			4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing
F 367 SS=D	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician.	F 367		

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F 367	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that Resident SS#5 did not receive the therapeutic diet as indicated on her printed meal ticket. Findings include: The printed meal ticket, dated 2/23/09 for Resident SS#5 stated, "Regular Lactose Free/Carb (carbohydrate) Controlled/NAS (no added salt)." On 2/23/09 at 12:50 PM, Resident SS#5 requested a surveyor to read her meal ticket and pointed to the words, "No milk, cheese, or ice cream". Observation of Resident SS#5's meal tray included vanilla ice cream. She stated that "this is a constant problem." Staff removed the ice cream and said they would get her something else. On 2/24/09 at lunchtime, Resident SS#5 was served a healthshake that was not "lactose free." Resident SS#5 complained that she was "lactose-intolerant" and could not drink this healthshake. Facility staff removed the healthshake from her tray. During an interview on 2/24/09 with the Food service Director, it was confirmed that the resident should not have received the ice cream or the healthshake on her tray and that this was an "ongoing problem." He stated that the facility did not carry lactose-free healthshakes and that he had just e-mailed the dietician to make her aware.	F 367 F 367	It is the practice of this facility to follow the Therapeutic Diet as prescribed by the physician. 1. Further investigation revealed that the physicians order for Resident SS #5 had been changed once it was determined the resident was lactose intolerant. The order was changed to nutrigrain bar and juice. The healthshake was given in error. — 2/25/09 2. The Food Service staff will be inserviced on following the therapeutic diet as prescribed by the physician and the importance of tray accuracy. — 4/24/09 3. The Registered Dietician will conduct random audits weekly for a period of 2 months to ensure compliance with tray accuracy with regards to prescribed diet. — 4/24/09 4. The results of the random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. — Ongoing	
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must -	F 371		

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F 371	Continued From page 29 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary area and interviews it was determined that the facility failed to prepare, serve, distribute, and store food under sanitary conditions. Findings include: 1. The food service director was asked to confirm the presence of a sanitizing agent using a test strip in the three compartment sink, in use at time of the test, on 2/23/09 at 2:05 PM. Sanitizer was not detected. Another batch of the sanitizer was made and another test strip was used to measure the concentration of the sanitizer detecting 100 PPM. This is lower than the 150-400 PPM concentration required to sanitize dishes at the three compartment sink. A third batch of the sanitizing solution was made and the proper concentration was detected. Dietary staff interview revealed a titration issue with the sanitizer unit. 2. A tray full of chicken Kiev patties (served on 2/17/09 lunch meal) were observed undated in the walk-in refrigerator on 2/23/09 at 1:40 PM. Interview with the dietary staff revealed that the food should had been dated or discarded. 3. The dietary staff hand sink temperature in the	F 371	F 371 It is the practice of this facility to procure, store, prepare, distribute and serve food under sanitary conditions. 1. The sanitizer dispenser was serviced and calibrated to deliver the proper PPM required to sanitize items in the three compartment sink. The Chicken Kiev patties were discarded. 2. The dietary staff hand sink hot water supply was under repair during the time the temperature was tested. It was repaired shortly after and the temps were retested my Maintenance. The temps were registering at 105 degrees, 3. The utensils that were observed stacked, uncovered and not inverted were immediately cleaned and sanitized and were stored unstacked, inverted and covered. 4. A thermometer was placed in the kitchen reach-in ice cream freezer. 5. All of the surfaces of the kitchen equipment containing grease/food debris including the sanitizer sink, the freezer floor, the hotel pans, the Garland convection oven, the frying pan, the perforated pans and the table surface were cleaned and sanitized.	2/23/09 2/23/09 2/18/09 2/17/09 2/20/09

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F 371	Continued From page 30 kitchen was detected at 85 degrees on 2/23/09 after lunch. This is lower than 110F required by the 1999 food code regulations. 4. Utensils such as forks, spoons and knives on 2/17/09 and 2/28/09 stored in the kitchen on the ready-to-use storage rack were observed stacked uncovered, not inverted, and with the food contact area exposed to contamination. Staff interview confirmed this finding. 5. Observation of the kitchen reach-in ice cream freezer on 2/17/09 revealed a missing thermometer. Temperature log review revealed inconsistent monitoring of this unit. Staff interview confirmed this finding. 6. On 2/17/09, four (4) out of eight (8) cookie sheets and ten (10) out of twelve (12) hotel pans were stacked wet on the ready-to-use storage rack. 7. On 2/17/09, greasy, encrusted grease/food debris, or black tar on the surfaces of kitchen equipment were observed as follows: a. inside the sanitizer sink of the three compartment sink b. inside the ice cream reach in freezer floor. c. 10 of 17 hotel pans were observed with grease on the food/nonfood contact surfaces d. on the racks, entrance, inside the garland convection ovens, the back fan of the convention ovens. e. the non-food contact areas of one (1) frying pan stored on the ready-to-use rack. f. on the food and nonfood contact area of three perforated pans g. on the table surface under meat slicer and the rack storing clean/dried pans.	F 371	6. The Dietary Staff will be inserviced on the proper PPM required for sanitizing in the three compartment sink. 4/6/09 7. The Dietary Staff will be inserviced on the proper storage of utensils and the proper labeling and/or discarding of leftovers. 4/6/09 8. The facility has developed a Kitchen Inspection Checklist that is administered by the Registered Dietician. (See attachment # 1) 3/3/09 9. The Corporate Dietician will perform random kitchen inspections using the Checklist weekly for a period of 1 month to ensure compliance. 4/24/09 10. The results of these inspections will be reported to the QI/QA committee. These inspections will continue monthly. Ongoing	

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F 371	Continued From page 31 h. on the nonfood contact of four (4) of eight (8) cookie sheets.	F 371		
F 372 SS=B	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations of the garbage dumpster area and interviews it was determined that the facility failed to dispose of garbage and refuse properly. Findings include: Observation of the dumpster area on 2/23/09 revealed a bag of soiled diapers on the ground in front of the dumpster. Additionally on 2/17/09 and 2/23/09, trash/debris and soiled gloves were observed on the ground around the compactor. This provides harborage for unwanted pests in the facility. Dietary staff person confirmed this finding	F 372	F 372 It is the practice of this facility to dispose of garbage and refuse properly. 1. The garbage and refuse observed in front of the dumpster on 2/23/09 was cleaned up and disposed of properly. 2. The Housekeeping and Food Service Staff will be inserviced on the proper disposal of garbage and refuse. 3. The Environmental Services Director will perform random audits 3 times a week for period of 4 weeks of the garbage dumpster area to ensure compliance with proper disposal of garbage and refuse. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	2/23/09 4/15/09 4/15/09 Ongoing
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		

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F 425	Continued From page 32 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interview, it was determined that the facility failed to ensure that pharmaceutical services were acquired and accurately dispensed in a timely manner for three (SS#1, SS#7, and SS#8) sub-sampled residents Findings include: Cross refer F309 example #2. 1. The facility failed to ensure that medications were accurately dispensed in a timely manner for Resident SS#1 after admission to the facility on 2/18/09. When the medication did arrive the next day it was incorrectly labeled with the name of a resident with a similar name. It took 24 hours for the resident to receive the physician ordered medications. 2. Resident SS#7 had a physician's order dated 11/22/08 that stated, "Klor-Con (Potassium) 8 meq. (millequivallent) tablet Take one tablet by mouth every day." During the medication pass observation on 2/23/09 at 8:45 AM, this medication was unavailable for the 9 AM scheduled dose. Nurse #4 checked the "Emergency Box" as per facility policy but it only contained Klor-Con 10 meq. so, she faxed a request to the pharmacy and documented this on	F 425	F 425 It is the practice of this facility to provide pharmaceutical services to meet the needs of each resident. 1. The medications for Resident SS#1 were delivered and administered at 8:00pm on 2/19/09. 2. The Nursing Staff will be inserviced on the proper procedure for notifying the pharmacy and physician when a delay in medication delivery occurs. 4/24/09 3. Nursing Administration will audit New Admission Med Orders to ensure compliance with timely medication administration. 4/24/09 4. These audits will be reported to the QI/QA committee. The committee will determine the need for further audits. Ongoing 5. The medications for Resident SS #7 were delivered and administered at 9:00am on 2/24/09 and for Resident SS #8 the medications were delivered and administered at 4:00pm on 2/19/09. 6. Further investigation revealed that the medications had not been ordered for refill in a timely manner. The Nursing Staff will be inserviced on the correct procedure for refilling of medications. 4/24/09	

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F 425	Continued From page 33 the back of the 2/09 MAR (Medication Administration Record). Review of Resident SS#7's 2/09 MAR revealed that she never received her Klor-Con until the next day, 2/24/09 at 9 AM. Findings were discussed with the Administrative staff during the informational meeting on 2/25/09. 3. Resident SS#8 had a physician's order dated 5/5/06 that stated, "Genteal Moderate Eye Drop (artificial tears) Instill 1 (one) drop into both eyes 2 (two) times a day." During the medication pass observation on 2/19/09 at 8:35 AM, this medication was unavailable for the 9 AM scheduled dose. Nurse #3 called a delivery request to the pharmacy and documented this medication as not given on the 2/09 MAR. She stated that a request had been placed the day before and was still waiting for delivery. Review of the 2/09 MAR revealed that Resident SS#8 missed a total of 2 doses of the eye drops (4 PM dose on 2/18/09 and 9 AM dose on 2/19/09). Findings were discussed with the Administrative staff during the informational meeting on 2/25/09.	F 425	7. Nursing Administration will perform Random Audits weekly for a period of 2 months of MAR's to ensure compliance with proper refills of medications. 8. The results of these audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	4/24/09 Ongoing
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441	F 441 It is the practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment.	

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F 441	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, review of other facility documentation, and staff interviews, it was determined that the facility failed to maintain an infection control program which investigated, controlled, and prevented transmission of infection within the facility. In addition, it was determined that the facility failed to conduct the two-step tuberculosis screening for 4 of 17 sampled staff as required by their procedures. (Employees #1, #3, #4 and #5). Findings include: 1. During the entrance tour of the facility on 2/17/09, surveyors were informed by staff of various departments within the facility that residents as well as staff had symptoms and/or signs of a gastrointestinal (GI) virus including nausea, vomiting, and/or diarrhea. However, observation during this day revealed that the facility continued with group activities and community dining. An interview with the DON and the facility's infection control coordinator on 2/19/09 at 1 PM revealed that the above symptoms and signs started over the weekend of February 14 and 15, 2009 and was contained to one (Warner Unit) of the three units. Subsequently, other residents in a different unit, Everett Unit had similar presentations as early as 2/17/09. However, only those residents with these symptom and/or signs were restricted from group activities and community dining. A subsequent interview with the DON 2/23/09 at	F 441	1. The facility contacted the Department of Public Health and implemented the Departments recommendations which included closing community dining, discontinuing group activities and performing Therapy on the units. 2/23/09 2. The facility has established benchmarks, based on recommendations from the Department of Public Heath, that when reached will trigger the Department's recommendations to be implemented. 2/27/09 3. Resident symptoms are reported during the facility's morning stand up meeting. The Infection Control Coordinator tracks the type and frequency and will notify Administration if established benchmarks are reached, at which time Department of Public Health is contacted and recommendations implemented. Ongoing 4. The Infection Control Coordinator will report results of type and symptom tracking to the QI/QA committee. The committee will determine the need for further follow up. Ongoing	

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F 441	Continued From page 35 1:30 PM revealed that the State of Delaware, Department of Public Health was contacted on 2/23/09 and the following recommendations were made to the facility to prevent transmission of infection. These included close community dining, discontinue group activities, and rehabilitation services until further notice. Although the facility identified the above symptoms and/or signs, the facility failed to control and prevent the transmission of the infection. 2a. Cross refer F253 Example #4. Resident #18 (who had symptoms of the GI virus) was observed during the medication pass on 2/20/09 at 12:47 PM. Nurse #5 failed to wash her hands after handing Resident #18 her nebulizer with ungloved hands. She informed the resident that she would return in about 15 minutes. Nurse #5 left the room and proceeded to the nurse's station where she documented in charts, spoke on the telephone, returned to med cart and restocked blister packs of medications to the cart and locked the cart. b. At 1 :04 PM, Nurse #5 measured Resident #18's pulse ox and returned it to the cart, again failing to wash her hands after resident contact and touched the med cart. c. At 1:15 PM, Nurse #5 returned to Resident #18's room, gloved, rinsed nebulizer in the bathroom and returned it to the resident's bedside and bagged it. She discarded her gloves and took Resident #18's empty water cup to refill it per resident's request. Nurse #5 then proceeded to the nurse's station and wrote in the doctor's communication book and handled several other books at the desk. Nurse #5 then left the Everett	F 441	5. Nurse #5 will be counseled and educated on the proper hand washing procedures to prevent the spread of infection. 4/1/09 6. The Nursing Staff will be inserviced on the proper hand washing procedures to prevent the spread of infection. 4/24/09 7. Housekeeper #1 and Housekeeper #2 will be counseled and educated on proper hand washing procedures to prevent the spread of infection. 4/1/09 8. The Housekeeping Staff will be inserviced on the proper hand washing procedures to prevent the spread of infection. 4/24/09	

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F 441	Continued From page 36 unit, went to the Warner unit, returned to the Everett unit, used the microwave and started to eat in the staff room. During and after the administration of Resident #18's nebulizer treatment, Nurse #5 was observed to enter and exit the resident's bedroom 3 times. Each time, she washed her hands just prior to resident care but, failed to wash her hands after resident care. During an interview on 2/24/09, the Assistant Director of Nursing confirmed that the nurse should have washed her hands before and after each resident contact to prevent the spread of disease and infection. Cross refer to F465, Example #4. 3.Housekeeping staff were observed on 2/19/09 to clean from resident room to resident room without handwashing. Staff were also observed using poor cleaning technique by cleaning multiple surfaces with the same item and without using sanitizer causing possible cross contamination of resident areas. 4. Employee #1 was hired 5/28/08, Employee #3 was hired 10/6/08, Employee #4 was hired 8/7/08, and Employee #5 was hired 7/7/08. There was no documentation that the second step of a two-step test for tuberculosis was conducted upon hire for these staff members. There was no record on file that the staff had a tuberculin test prior to work at this facility. An interview with the ADON on 2/25/09 at 12:15 PM confirmed that the tuberculosis second step was not conducted. According to the facility's policy and procedure, a two-step tuberculin test is provided and read at the time of hire.	F 441	9. The Infection Control Coordinator will perform Random Audits weekly for a period of 2 months of the Nursing Staff and Housekeeping Staff to ensure compliance with proper hand washing procedures.	4/24/09
			10. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing
			11. Employees #1, #3, #4, #5 were administered a two-step tuberculin test.	2/25/09
			12. An audit of employee files was conducted to ensure documentation of administration of a two-step tuberculin test was on file.	
			13. The Staff Development Coordinator will conduct an audit at the time of hire and annually thereafter of employee files to ensure compliance with documentation of administration of a two-step tuberculin test is on file.	Ongoing
			14. The results of these audits will be reported to the QI/QA committee. These audits will continue quarterly.	Ongoing
F 445	483.65(c) INFECTION CONTROL - LINENS	F 445		

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F 445 SS=E	Continued From page 37 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations of the handling of soiled linens throughout the survey, it was determined that the facility failed to handle and store linens so as to prevent the spread of infection. Findings include: 1. On 2/23/09 at 6:30 AM, two of three soiled linen carts in the 300 SPA or resident common shower room were overflowing and uncovered. One overflowed soiled linen cart had unbagged soiled resident linen. 2. On 2/23/09 at 7:15 AM, four bags of soiled linen were observed stored on the floor of the 200 SPA or common resident shower room. Nursing staff interview confirmed the bags should have been in the soiled linen carts.	F 445	It is the practice of this facility to handle, store, process and transport linens so as to prevent the spread of infection. 1. The facility will purchase additional linen carts so as to prevent the overflowing of soiled linen. 4/15/09 2. The Nursing Aides will be inserviced on the proper methods of handling, transportation and storage of linen. 4/24/09 3. The Environmental Services Director will perform Random Audits 3 times a week for 4 weeks to ensure compliance with proper handling, transportation and storage of linen. 4/24/09 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. Ongoing	
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour, it was determined that the facility failed to provide a sanitary and safe environment. Findings include:	F 465	It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and public. 1. The unlabeled personal care items observed in the shower rooms were removed. The unlabeled pink resident bins observed in SPA were removed. The soiled gloves were removed. 2/17/09 The unlabeled person care items observed in resident bathrooms and on linen carts were removed. The trash bags observed on the floor and the uncovered trash barrels were removed. 2/23/09	

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F 465	Continued From page 38 1. Unlabelled personal care items belonging to residents such as body wash shampoo, perineal wash, baby oil, shaving cream, sanitizer, protective ointment containers, were observed in the shower stalls of the 100 and 300 shower rooms unlabeled and accessible to residents on 2/17/09 at 11:30 AM. Soiled gloves were also observed on the floor of the 300 shower room. On 2/23/09 at 7:10 AM, a protective cream container in a shower stall, and two containers of protective ointments in the toilet area were observed in the 200 SPA or common resident shower room. Staff interviews confirmed the bottles should have been removed after the resident's bath was over. Additionally, two unlabelled pink resident basins full of personal items such as perineal wash, shaving cream, hair brushes, dimethicone protectant, shampoo, protective ointment were observed in the 300 SPA on 2/17/09 at 10:45 AM. 2. On 2/17/09 at 11:15 AM, a perineal wash, body lotion, hand cream were observed on top of a shared toilet in resident room 311 unlabelled and accessible to other residents. An unlabelled container of body ointment was observed on a shared handsink of resident room 316. On 2/23/09 at 6:30 AM, a perineal wash and sanitizer containers were observed on top of the clean linen cart on the hallway outside room 315. 3. During the environmental tour with the maintenance and environmental services director on 2/17/09 at 9:43 AM, two large bags full of trash on the floor and two uncovered trash barrels full of trash were observed on the 200 unit soiled utility room. On 2/17/09, interview with the staff confirmed the bags should have been inside the	F 465	2. The Environmental Services Director will add the aforementioned items to the Daily Rounds Checklist. These items will be monitored during the daily rounds. 3. Administration will conduct random audits weekly for a period of 2 months of the Shower Rooms, SPA and soiled utility room to ensure compliance. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits. 5. Housekeeper #1 and Housekeeper #2 will be counseled and educated on proper hand washing procedures to prevent the spread of infection. 6. The Housekeeping Staff will be inserviced on the proper hand washing procedures to prevent the spread of infection.	4/1/09 4/24/09 Ongoing 4/1/09 4/24/09

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F 465	Continued From page 39 trash barrels and the barrels should have been covered. 4. On 2/19/09 at 2:00 PM, two (2) of two (2) cleaning personnel were not observed washing hands after cleaning a resident room and entering a second resident room. On 2/19/09 at 2:00 PM, one cleaning staff of two (2) was observed using a Johnny mop to clean the inside of the toilet bowl of resident room 207 without sanitizer and then proceeded to use the same Johnny mop to scrub the outside surface of the toilet. This staff was observed not wearing gloves on her left hand per standard procedures, nor observed washing her hands during the cleaning process, while mopping the floor and moving resident furniture surfaces with her dirty hands such as the bed table. The staff was observed then using the same Johnny mop to scrub the inside of the toilet bowl and to clean the commode chair section. She was then observed using a rag, without sanitizer or chemicals, to clean/scrub the top of the toilet top lid, the toilet tank, the wall behind the toilet, and then wiped the handrail next to toilet. With the same rag a few minutes later, she scrubbed the top of the white resident cart next to the handsink. Additionally, this same staff mopped the floor and did not pick up the two mats in the room to clean the floor and was not observed cleaning the mats on the floor. She cleaned the floor but never mopped or cleaned the mat next to both resident beds. On 02/19/09, interview with the Environmental Director revealed hand washing is required between resident room to room cleaning.	F 465	7. The Housekeeper observed in room 207 will be counseled and educated on the proper procedures for 5 step Daily Room Cleaning, 7 Step Daily Washroom Cleaning and proper hand washing procedures.	4/1/09
			8. The Housekeeping Staff will be inserviced on the proper procedures for 5 Step Daily Room Cleaning and 7 Step Daily Washroom Cleaning. (See attachment # 2)	4/24/09
			9. The Environmental Services Director will perform random audits 3 times a week for a period of 4 weeks of the Housekeeping Staff to ensure compliance with proper cleaning procedures.	4/24/09
			10. The results of these audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	Ongoing

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F 467 SS=E	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations of the facility's janitor closet, resident rooms, and staff interviews, it was determined that the facility failed to maintain adequate ventilation as reflected by malfunctioning exhaust vents. Findings include: On 2/17/09 during the environmental tour, the exhaust vents in the following areas were not drawing air into the vent or working: 1. The exhaust vents in the bathrooms of resident rooms 106, 113, 205, 206, 207, 209, 214, 219, 223, 227, 229, 304, and 306. 2. The exhaust vent in the Everett janitor closet. Interview with the facility's Maintenance Director confirmed these findings.	F 467	F 467 It is the practice of this facility to provide adequate outside ventilation by means of windows, mechanical ventilation or a combination of the two. 1. The facility employed an outside contractor to rebalance the ventilation system. The system was then checked at the affected areas and they were functioning properly.	4/1/09
			2. The facility will perform quarterly preventive maintenance on the ventilation system to ensure proper functioning.	Ongoing
			3. The Maintenance Director will perform weekly rounds to check for proper functioning of the ventilation system.	Ongoing
F 500 SS=B	483.75(h) USE OF OUTSIDE RESOURCES If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of	F 500	4. Random Audits will be performed by Administration/Maintenance to ensure proper functioning. (ONCE PER MONTH)	Ongoing

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F 500	Continued From page 41 the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of the facility contract book documentation and staff interviews, it was determined that the facility failed to maintain a contract for dental services. Findings include: Review of the contract book on 2/23/09 revealed that the facility lacked a written dental agreement. Staff interview confirmed this finding.	F 500	F 500 It is the practice of this facility to provide services to residents through the use of outside resources under the guidelines outlined in section 1861(w) of the Act. 1. At the time of survey, the facility was providing dental services to the residents through outside sources; however there was not a written agreement with the outside source. 2. The facility will obtain dental services through outside sources by way of a written agreement.	4/24/09
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews it was	F 514	3. Administration will perform an audit of the facility contract binder upon set-up of the agreement and annually thereafter to ensure compliance. 4. The results of these audits will be reported to the QI/QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 02/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADMEADOW HEALTHCARE	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 42 determined that the facility failed to maintain complete and accurate documentation for one (#19)out of 23 residents in the sample. Findings include: Resident #19 was originally admitted to the facility on 1/9/09 with diagnoses including syncope, collapse, and abnormal gait. The intial MDS assessment dated 1/12/09 indicated that the resident had range of motion limitation of the one foot. On 2/23/09 at 1:45 PM, Resident #19 was observed out of bed, in the wheelchair with a brace of his left lower extremity. Interview with the resident revealed that the facility staff assisted in placing and removing the brace. Review of the initial physical therapy evaluation dated 1/9/09 documented Resident #19 using the ankle foot orthosis (AFO) when out of the bed. Record review lacked evidence of a physician's order for the the left AFO and an interview with Nurse # 7 on 2/23/09 at 2:30 PM confirmed that the facility failed to obtain the order for this orthosis.	F 514	F 514 It is the practice of this facility to maintain clinical records on each resident in accordance with accepted standards, and that are complete, accurate, accessible and organized. 1. A physicians order was obtained for Resident #19 for the left ankle foot orthosis (AFO). A care plan was also developed for the use of the left ankle foot orthosis (AFO). 2. An audit of all orders and care plans was conducted to ensure compliance with actual care needs of the resident's. 3. The RNAC will perform random audits weekly for a period of 2 months to ensure compliance with orders and care plans matching the actual care needs of the residents. 4. The results of these random audits will be reported to the QI/QA committee to determine the need for further audits.	2/23/09 3/20/09 4/15/09 Ongoing

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085050	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/25/2009
NAME OF PROVIDER OR SUPPLIER **BROADMEADOW HEALTHCARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **500 SOUTH BROAD STREET MIDDLETOWN, DE**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to have a Minimum Data Set (MDS) assessment which accurately reflected the resident's status for one (#6) out of 23 sampled residents. Findings include: Review of Resident #6's quarterly MDS assessment dated 10/31/08 indicated the presence of two, Stage 2 pressure ulcers and one, Stage 4 pressure ulcer. Subsequent MDS assessment dated 1/21/09 indicated that the resident continued to have two, Stage 2 pressure ulcers and a new Stage 4, stasis ulcer. Record review lacked evidence of a Stage 4 stasis ulcer. An interview with the Registered Nurse Assessment Coordinator on 2/23/09 at 12:20 PM confirmed that the resident did not have a Stage 4 stasis ulcer as documented on the 1/21/09 MDS assessment.
F 497	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085050	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/25/2009
NAME OF PROVIDER OR SUPPLIER **BROADMEADOW HEALTHCARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **500 SOUTH BROAD STREET MIDDLETOWN, DE**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 497	Continued From Page 1 needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of facility documents on 2/23/09 and staff interview, it was determined that the facility failed to ensure that one (Employee #6) out of five sampled certified nurse assistants (CNA) received the required 12 hours of in-service education to improve their continued quality of care performance. Findings include: One out of five CNA records reviewed (Employee #6) documented that the staff had less than the required 12 hours of in-service for the previous anniversary year of service. Employee #6 in the sample had 8 hours of in-service for the previous anniversary years of service.

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	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint visit was conducted at this facility from February 17, 2009 through February 25, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The census on the first day of the survey was one hundred and nine (109). The survey sample totaled twenty three (23) which included twenty (20) active and three (3) closed records. An additional eight (8) sub-sampled residents were included for observations.	
3201	**Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	

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	Cross-refer to CMS 2567-L survey date completed 2/25/09, F226, F246, F253 Examples (4) a and (4)b, F254, F309, F311, F312, F314, F315, F323 Examples (5) through (7), F332, F441 Examples (2) a through (2) c, F465 Examples (1) through (3), F497.	Cross Reference CMS 2567 to F226, F246, F253 Examples (4)a and (4)b, F254, F309, F311, F312, F314, F315, F323 Examples (5) through (7), F332, F441 Examples (2)a through (2)c, F465 Examples (1) through (3), F497
3201.6.1.3	**The nursing facility shall have written agreements for promptly obtaining required laboratory, x-ray and other ancillary services.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F500.	Cross Reference CMS 2567 to F500.
3201.6.8	**Food Service**	
3201.6.8.1	**Meals**	
3201.6.8.1.5	**Therapeutic diets, mechanical alterations and changes in either must be prescribed by an attending physician within 72 hours of implementation. All meals and snacks shall be served in accordance with the therapeutic diet, if prescribed.**	Cross Reference CMS 2567 to F367.

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	This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 2/25/09, F367.	
3201.6.9	**Housekeeping and Laundry Services**	
3201.6.9.1	**The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F253, F465.	Cross Reference CMS 2567 to F253, F465
3201.6.9.5	**The facility's handling, storage, processing and transporting of linens shall comply with facility infection control policies and procedures.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F445.	Cross Reference CMS 2567 to F445.

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3201.6.11	**Medications**	
3201.6.11.1	**Medication Administration**	
3201.6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 2/25/09, F332 Example #2.	Cross Reference CMS 2567 to F332 Example #2
3201.6.12	**Communicable Diseases**	
3201.6.12.1.3	**The nursing facility shall ensure that the necessary precautions stated in the policies and procedures are followed.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed	Cross Reference CMS 2567 to F465 Example (4)

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	2/25/09, F465 Example (4).	
3201.6.12.2	**Specific Requirements for Tuberculosis**	
3201.6.12.2.3	**All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F441.	Cross Reference CMS 2567 to F441
3201.6.12.2.6	**Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.**	

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 2/25/09, F441.	Cross Reference CMS 2567 to F441.
3201.6.12.4	**Employee Health**	
3201.6.12.4.1	**All employees shall receive education and training on standard precautions, use of personal protective equipment, the importance of hand hygiene, the facility's infection control policies and reporting of exposures to blood or other potentially infectious materials.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F465 Example (4).	Cross Reference CMS 2567 to F465 Example (4)
3201.6.13	**Infection Control**	
3201.6.13.1	**Infection Control Committee**	
3201.6.13.1.4	**The committee is responsible for the development and coordination of policies and procedures to accomplish the following:**	
3201.6.13.1.4.1	**Prevent the spread of infections and**	

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	communicable diseases	
3201.6.13.1.4.2	**Promote early detection of outbreaks of infection**	
3201.6.13.1.4.3	**Ensure a sanitary environment for residents, staff and visitors**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 2/25/09, F465 Example (4).	Cross Reference CMS 2567 to F465 Example (4)
3201.7.4	**Physical Environment Requirements**	
3201.7.4.3	**Bathrooms**	
3201.7.4.3.1	**Bathroom walls and floors shall be impervious to water. Bathrooms shall have at least one window or mechanical ventilation.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 2/25/09, F467 Example (1).	Cross Reference CMS 2567 to F467 Example (1)
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food**	

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	Code. **This requirement is not met as evidenced by:** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections the State of Delaware Food Code. Findings include: **3-501.17 Ready-to-Eat, Potentially Hazardous Food, Date Marking.** **(A) Except as specified in ¶ (E) of this section, refrigerated, Ready to Eat, potentially hazardous Food prepared and held refrigerated for more than 24 hours in a food establishment shall be clearly marked at the time of preparation to indicate the date by which the food shall be consumed which is, including the day of preparation:** **(2) 4 calendar days or less from the day the Food is prepared, if the food is maintained at 7°C (45°F) or less as specified under section 3-501.16 (C)** **(D) Except as specified in ¶¶ (E) and (F) of this section, a container of refrigerated, ready-to-eat, potentially hazardous food**	

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	prepared and packaged by a food processing plant and subsequently opened and frozen in a food establishment shall be clearly marked: **(2) To indicate the time between the opening of the original container and freezing that the food is held refrigerated and which is, including the day of opening the original container:** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F371, Example (2). **4-302.12 Food Temperature Measuring Devices** **Food temperature measuring devices shall be provided and readily accessible for use in ensuring attainment and maintenance of food temperatures.** Cross refer to CMS 2567-L survey date completed 2/25/09, F371 Example (5). **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness.***	Cross Reference CMS 2567 to F371 Example (2) Cross Reference CMS 2567 to F371 Example (5)

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	A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at exposure times specified under ¶ 4-703.11(C) shall be listed in 21 CFR 178.1010 Sanitizing solutions, shall be used in accordance with the EPA-approved manufacturer's label use instructions, and shall be used as follows: **(C) A quaternary ammonium compound solution shall:** **(1) Have a minimum temperature of 24°C (75°F),** **(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, and** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F371 Example (1). **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.*** **(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.**	Cross Reference CMS 2567 to F371 Example (1)

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	(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. **(C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F371 Example (7). **4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** **(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:** **(1) In a self-draining position that allows air drying; and** **(2) Covered or inverted.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F371, Examples (4) and (6). **5-202.12 Handwashing Facility, Installation.**	Cross Reference CMS 2567 to F371 Example (7) Cross Reference CMS 2567 to F371 Examples (4) and (6)

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	(A) A handwashing lavatory shall be equipped to provide water at a temperature of at least 43°C (110°F) through a mixing valve or combination faucet. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F371 Example (3). **6-501.114 Maintaining Premises, Unnecessary Items and Litter.** **The PREMISES shall be free of:** **(B) Litter.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F372.	Cross Reference CMS 2567 to F371 Example (3) Cross Reference CMS 2567 to F372.
3201.7.6 **3201.7.6.1**	**Sanitation and Laundry** **The facility shall provide for the safe storage of cleaning materials, pesticides and other potentially toxic materials.** **This requirement is not met as evidenced by:**	

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	Cross-refer to CMS 2567-L survey date completed 2/25/09, F323, Examples (3), (4) a, b, c, d, and e.	Cross Reference to CMS 2567 to F323 Examples (3), (4)a, b, c, d and e
3201.8.0	**Emergency Preparedness**	
3201.8.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.**	
	This requirement is not met as evidenced by:	3201.8.2
	Based on review of the fire drill reports, no fire drills were conducted during the third quarter of the third shift of 2008, or in June 2008 through October 2008. An interview with the Maintenance Director confirmed this.	The facility contacted Coker Fire Drill Corporation and was able to obtain a copy of the fire drill conducted 8/12/2008 for the 11-7 shift. A copy is attached.
16 Del. C., Chapter 11, Subchapter II, §1121	**Patient's Rights**	
	It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a	

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	declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following: **Patient's Rights (1)** **Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/25/09, F241. **Patient's Rights (6)** **Each patient and resident shall receive respect and privacy in the patient's or resident's own medical care program. Case discussion, consultation, examination and treatment shall be confidential, and shall be conducted discreetly. In the patient's discretion, persons**	Cross Reference CMS 2567 to F241.

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	not directly involved in the patient's care shall not be permitted to be present during such discussions, consultations, examinations or treatment, except with the consent of the patient or resident. Personal and medical records shall be treated confidentially, and shall not be made public without the consent of the patient or resident, except such records as are needed for a patient's transfer to another health care institution or as required by law or third party payment contract. No personal or medical records shall be released to any person inside or outside the facility who has no demonstrable need for such records. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey report date completed 2/25/09, F164. **Patient's Rights (25)** **Every patient and resident shall be free to make choices regarding activities, schedules, health care and other aspects of his/her life that are significant to the patient or resident, as long as such choices are consistent with the patient's or resident's interests, assessments and plan of care and do not**	Cross Reference CMS 2567 to F164.

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	compromise the health or safety of the individual or other patients or residents within the facility. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 2/25/09, F242.	Cross Reference CMS 2567 to F242.

Provider's Signature _____ Title Administrator Date 4/9/09